Hailstone Earliest Settlers

Who Came	Date Came	HBUM	Ped	FGS	Pict.	Hist.

Refs: Dean Hailstone—SLCu
HBUM pp.

FOR STATE USE ONLY

PHYSICIAN INVOICE

UTAH DEPARTMENT OF SOCIAL SERVICES

Mail Claim To:
Medical Claims Section
Dept. Of Social Services
Box 2500
Salt Lake City, Utah 84111
Phone 533-6571

XI. Rev.

1. Patient's Last Name	2. First Name	3. MI	4. Age	5. Sex	6. Patient's Address and Zip Code
LONG	Stephani		22	F	86 West 2nd South Heber City, Utah 84032

7. Client ID Number	8. Expiration date of ID Card
53050-90877	30 January 1978

9. Provider Name and Address	10. Provider No.	11. Medical Record No.	12. Date Patient first consulted you for this condition
R. R. Green, MD 45 S,. Main St. Heber City, Utah 84032 Phone: 654-1822	108448		1-21-78

13. Indicate if Special Type of Service
- ☐ A. Anesthesiology
- ☐ B. Assistant at Surgery
- ☐ C. Professional Component

14. If Anesthesiology Claim, Enter Number of Minutes

15. (A) Primary Diagnosis, Problem or Injury: Vaginal infection — 16. (A) H-ICDA Code

(B) Secondary Diagnosis — (B) H-ICDA Code

(C) Tertiary Diagnosis — (C) H-ICDA Code

(D) Quarterary Diagnosis — (D) H-ICDA Code

17. If this condition required a prior authorization, enter the prior authorization number:

18. If patient was a referral, enter name of referring practitioner:

19. Provider No.

20. Does patient have health insurance other than Medicaid? A ☐ Yes B ☒ No

21. If yes, enter patient's health insurance policy number

22. If patient has health insurance, give insurance company name and address

23. Was patient involved in accident? A ☐ Yes B ☒ No

SERVICES RENDERED:

NOTE: Use line 1 to describe hospital visits only.

24. Line No.	25. Dates of Service From (mo day yr)	Thru (mo day yr)	26. Procedure (USMA Code Accepted)	27. Number Visits	28. Family Planning? (1)	29. Place of Service (2)	30. Diagnosis Treated (3)	31. Charge	32. (Leave Blank)
1			(HOSPITAL SERVICES ONLY) 902						
2	1 21 78		Office Call & Exam 90050			1	A	10.00	
3									
4									
5									
6									
7									
8									

(1) Family Planning: If the service provided was for family planning purposes, enter "Y"

(2) Place of Service Codes:
1 Office
2 Patient's Home
3 Inpatient Hospital
4 Outpatient Hospital
5 Clinic
6 Skilled Nursing Facility
7 Intermediate Care Facility
8 Other

(3) Diagnosis Treated, Enter:
'A' if Primary
'B' if Secondary
'C' if Tertiary
'D' if Quarternary
'E' if Combination

33. TOTAL CHARGE	10.00	
34. Less Amount Received from Other Sources	-0-	36. Billing Date (mo/day/yr)
35. NET CHARGE	10.00	1-23-

PROVIDER CERTIFICATION I certify that: (1) The services on this statement were rendered in behalf of the patient named herein; that this claim constitutes the full and complete charge for services described above; that I will make no further claim for payment of this service; that these services have been provided without discrimination based upon race, color, sex, creed, or national origin; (2) The information I have provided on this form is true, accurate, and complete. I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under Utah's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State agency may request. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of material fact, may be prosecuted under applicable Federal or State laws.

AUTHORIZED SIGNATURE _____